Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Medicaid Fraud Control Unit, Tennessee Bureau of Investigation
Docket No. A-15-32
Decision No. 2644
June 22, 2015

DECISION

The Medicaid Fraud Control Unit, Tennessee Bureau of Investigation (Appellant) appeals a decision by the Inspector General (I.G.) for the Department of Health and Human Services to disallow $36,248 in federal financial participation (FFP) claimed for expenses it incurred in conducting an investigation during 2011. That investigation involved possible undue influence and public corruption offenses by two elected state officials alleged (in a complaint filed with the Appellant) to have pressured the state Nursing Board to reinstate the licenses of three nurse practitioners accused of patient neglect and abuse that led to patient deaths.

Appellant claimed that the expenses should be eligible for FFP because the 2011 investigation was "inextricably related" to and "mirrored allegations" in an investigation it conducted beginning in 2005 involving the same three nurse practitioners, an investigation that the I.G. had found eligible for FFP. Appellant also claimed that the costs were eligible for FFP because it was necessary to investigate the potential consequences of the possibly unlawful reinstatement of the nurse practitioners' licenses on future patient deaths and submission of medically unnecessary claims to Medicaid.

Based upon an audit performed by the I.G.'s Office of Evaluation and Inspections (OEI), the I.G. determined the 2011 investigative costs were not eligible for FFP because that investigation did not involve allegations of fraud in the administration of Tennessee's Medicaid program, in the provision of Medicaid services or in the activities of Medicaid providers or allegations of patient abuse or neglect in a state Medicaid-funded facility, as required by the applicable statute and regulations. The I.G. also determined that these investigative costs were not eligible for FFP because the 2011 investigation of the elected state officials did not involve any substantial allegations or other indications of Medicaid fraud.

For the reasons explained below, we sustain the I.G.'s disallowance of $36,248 in FFP that Appellant claimed for costs incurred during the 2011 investigation.

Legal Background

Medicaid Fraud Control Units (MFCUs) are entities of state governments certified by the I.G. that are required to investigate and prosecute Medicaid fraud, as well as patient abuse and neglect in health care facilities funded by Medicaid. *See* 42 C.F.R. Part 1007. FFP is the federal share of allowable costs incurred by a state in operating its Medicaid program, including a state's MFCU expenditures. Section 1903(a)(6) of the Social Security Act (Act)[1] authorizes states to claim FFP for the costs attributable to the establishment and operation of an MFCU as described in section 1903(q) of the Act. As set forth in that section of the Act, the function of a MFCU is to conduct --

> a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assistance and the activities of providers of such assistance under the [State's Medicaid program] under [Title XIX of the Act]….

Act § 1903(q)(3). Additionally, an MFCU is required to have procedures for reviewing complaints of abuse and neglect of patients in certain types of facilities receiving Medicaid payment. *See* Act § 1903(q)(4)(A).

The I.G. issued regulations to implement the provisions of sections 1903(a)(6) and 1903(q) of the Act in 42 C.F.R. Part 1007. In accordance with section 1007.11(a), an MFCU's general duties and responsibilities include investigating and prosecuting "fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan." An MFCU must "review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities[.]" Section 1007.11(b)(1).

The regulation at section 1007.19(d)(1) defines what MFCU investigation costs are <u>eligible</u> for FFP. That regulation provides that FFP is available for "costs attributable to the specific responsibilities and functions set forth in [sections 1007.11(a) and (b)(1)] in connection with the investigation and prosecution of *suspected fraudulent activities and the review of complaints of alleged abuse or neglect of patients in health care facilities*." Section 1007.19(d)(1) (emphasis added).

The regulation at section 1007.19(e)(1) describes MFCU investigation costs that are <u>not eligible</u> for FFP. That regulation provides "FFP is not available . . . for . . . [t]he

[1] The current version of the Act is at http://www.socialsecurity.gov/OP_Home/ssact/ssacttoc.htm with a reference to the corresponding United States Code chapter and section, or a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

investigation of cases involving program abuse or other failures to comply with applicable laws and regulations, *if these cases do not involve substantial allegations or other indications of fraud*." Section 1007.19(e)(1) (emphasis added).

Appellant bears the burden of demonstrating that the costs of the 2011 investigation are eligible for FFP. *Executive Office of Health & Human Servs.*, DAB No. 2218, at 11 (2008) (burden is on the State to establish that the disallowed FFP was for allowable Medicaid expenditures).

Case Background[2]

On October 21, 2005, Appellant opened an investigation (2005 investigation) into allegations that three nurse practitioners were overprescribing medications, which resulted in patient deaths. Appellant's Notice of Appeal at 1. On March 11, 2010, the Tennessee Board of Nursing (Nursing Board) took emergency action to suspend the licenses of the nurse practitioners, based on these allegations of misconduct.[3] *Id.* at 1-2.

In 2011, Appellant received complaints that two members of the Tennessee state legislature had unlawfully pressured the Nursing Board to reinstate the licenses of the suspended nurse practitioners. *Id.* at 2. In response, Appellant opened an investigation into the allegations against the two legislators (2011 investigation). *Id.* Appellant's investigation was conducted under jurisdiction created by a Tennessee state law over cases involving any offense of corruption of or misconduct by a public official as prohibited by Tenn. Code. Ann. § 38-6-102(b)(1)(B). *Id.*; I.G. Br. at 6. Appellant subsequently claimed $36,247.53 in FFP for costs involving the 2011 investigation, which included an indirect cost amount of $5,676.00. I.G. Ex. 4.

OEI conducted an audit and on-site review of Appellant in 2012 and issued a final report in April 2013. I.G. Ex. 2. In its final report, OEI found that Appellant improperly claimed FFP for the costs of the 2011 investigation because Appellant's investigation did not involve allegations of fraud in the administration of the Medicaid program, in the provision of Medicaid services, or in the activities of Medicaid providers, as required by the applicable legal authorities. *Id.* at 11, citing Act § 1903(q)(3); 42 C.F.R. §§ 1007.11(a) and 1007.19(d).

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[2] We note Appellant represented that due to confidentiality and public records requirements under Tennessee law, "we are unable to cite to and attach components of the specific case files addressed herein." December 26, 2014 ltr. (Appellant's Notice of Appeal). Thus, Appellant stated it would use "[g]eneral statements regarding the findings and genesis of the case . . . to establish the events that occurred." *Id.* The facts in this section are drawn from the record and appear to be undisputed. I.G. Br. at 6-7.

[3] The I.G. agreed that Appellant appropriately claimed FFP for the 2005 investigation costs because that investigation involved allegations of patient abuse in a health care facility funded by Medicaid. I.G. Br. at 6, citing section 1007.11(b)(1).

In a letter dated August 6, 2014, the I.G. issued a final determination to disallow the $36,248 in claimed FFP because the costs of Appellant's 2011investigation were not eligible for FFP in accordance with the applicable statute and regulations. I.G. Ex. 5, at 2, citing Act § 1903(q)(3); 42 C.F.R. §§ 1007.11(a), (b)(1), and 1007.19(d)(1), and (e)(1).

Appellant requested reconsideration of the disallowance. I.G. Ex. 6. In a letter dated October 28, 2014, the I.G. affirmed the disallowance. October 28 ltr. Attached to Appellant's Notice of Appeal. The present appeal ensued.

Analysis

A. *The 2011 investigation costs are not eligible for FFP under the applicable statute and regulations even if they were "inextricably linked" to or "mirrored" the allegations in the 2005 investigation.*

In its August 6 letter, the I.G. determined that these investigative costs were not eligible for FFP because the 2011 investigation did not involve allegations of fraud in the administration of Tennessee's Medicaid program, in the provision of Medicaid services or in the activities of Medicaid providers and also did not involve allegations of patient abuse or neglect in a state Medicaid-funded facility. I.G. Ex. 5, at 2, citing Act §1903(q)(3); 42 C.F.R. §§ 1007.11(a), (b)(1); 1007.19(d)(1) and (e)(1).

Appellant argues that the costs from the 2011 investigation are eligible for FFP because the allegations involving the circumstances surrounding the Nursing Board's reinstatement of the nurse practitioners were "inextricably linked" to the 2005 investigation of these same nurse practitioners and their roles in patient deaths. Appellant's Notice of Appeal at 2, 3. Appellant further argues that it was appropriate to claim FFP for the 2011 investigation because "the allegations in the second investigation mirrored those in the first." *Id*. at 3. These arguments are without merit.

The standard under the regulations for determining whether MFCU investigative costs are eligible for FFP is not whether there is some possible connection or commonality of facts or participants from a past or separate investigation. Rather, the standard for determining FFP eligibility as defined by the regulations is whether a MFCU was investigating: 1) violations of state laws pertaining to fraud in (a) the administration of the Medicaid program; (b) the provision of medical assistance; or (c) the activities of providers of medical assistance under the State Medicaid plan; or 2) complaints of abuse or neglect in a health care facility funded by Medicaid. Sections 1007.11(a), (b)(1); 1007.19(d)(1). For the 2011 investigative costs to be eligible for FFP, Appellant's investigation therefore must involve either an allegation of fraud in one of three activities named or a complaint of abuse or neglect of residents.

Appellant represented that the 2011 investigation was conducted to determine whether two elected state officials improperly influenced the Nursing Board to reinstate the nurse practitioners' licenses and whether that conduct amounted to an offense involving corruption of or misconduct by a public official pursuant to Tenn. Code. Ann. § 38-6-102(b)(1)(B). Appellant's Notice of Appeal at 2. Accepting this representation as true, it is thus reasonable to conclude that the 2011 investigation did not involve either an investigation into any "suspected fraudulent activities" or "the review of complaints of alleged abuse or neglect of patients in health care facilities" by the elected state officials, as required by section 1007.19(d)(1). Nor did it involve an allegation of fraud in any of the other specified activities under the regulations as necessary to establish eligibility for FFP. *See* sections 1007.11(a), (b)(1); 1007.19(d)(1).

The mere fact that the allegations raised against the elected state officials in the 2011 investigation may have resulted in some overlap with facts and participants at issue in the 2005 investigation is not a sufficient legal basis for us to conclude that the 2011 investigative costs are eligible for FFP.

Thus, the 2011 investigation costs are not eligible for FFP under the applicable statute and regulations even if they were "inextricably linked" to or "mirrored" the allegations in its 2005 investigation.

B. The 2011 investigation costs are also not eligible for FFP under section 1007.19(e)(1) because these costs were not incurred in an investigation into any substantive allegations or other indications of Medicaid fraud.

In its August 6 letter, the I.G. further determined that FFP for these investigative costs was not available because the 2011 investigation of the elected state officials did not involve any substantial allegations or other indications of Medicaid fraud, as required by section 1007.19(e)(1). I.G. Ex. 5, at 2. Appellant argued that these costs are nonetheless eligible for FFP under section 1007.19(e)(1) because:

> The MFCU was investigating fraudulent activities of providers of medical assistance under the State Medicaid plan, in that if allowed to continue prescribing beyond the scope of medical necessity, the nurse practitioners *could* not only continue to cause unnecessary deaths of patients, but also continue to defraud the State Medicaid plan by either submitting claims for payment for medically unnecessary activities, or by prescribing drugs that are provided utilizing the State Medicaid plan.

Appellant's Notice of Appeal at 3 (emphasis added). Appellant further asserted that the 2011 investigation costs should be eligible for FFP because "reinstatement [of the nurse practitioners' licenses] created the possibility of further patient deaths, necessitating a

determination of how and why the licenses were reinstated, and whether they could or should be again suspended or revoked[.]" *Id*. These arguments are without merit.

The 2011 investigation of the elected officials had a different focus than the 2005 investigation of the nurse practitioners. The 2011 investigation did not involve any "substantial allegations or other indications of fraud" in the Medicaid program, as required by section 1007.19(e)(1). Appellant's arguments that these investigational costs fall within the scope of that regulation are based upon stringing together a series of hypothetical events and speculating that the reinstatement of the nurse practitioners' licenses *could* result in further beneficiary deaths or *could* result in the fraudulent billing of Medicaid for medically unnecessary services.

The plain language of section 1007.19(e)(1) provides that MFCU investigational costs are eligible for FFP only for those investigations that *actually* involve a "substantial allegation or other indication of fraud[]" rather than for those involving hypothetical or highly speculative scenarios such as posited by Appellant here.

Thus, the 2011 investigation costs are not eligible for FFP under section 1007.19(e)(1) because they did not result from an investigation into any substantial allegations or other indications of fraud.

Conclusion

For all of the foregoing reasons, we sustain the I.G.'s disallowance of $36,248 in FFP that Appellant claimed for costs incurred during the 2011 investigation.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member